

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02418

2453

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Royal Oak		c. LENGTH OF STAY IN 1b 8 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> rural Royal Oak		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) AGNES ANTHONY ANDREW			4. DATE OF DEATH Feb. 20, 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1957		9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Palmer Andrew			14. MOTHER'S MAIDEN NAME Toni Marie Rose		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Palmer Andrew Address Royal Oak, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilat. middle ear infection 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Feb 21-58	
EXAMINER'S NAME (Type) Dr. Louis S. Welty		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	
				22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR FEB 24 '58	
				24b. REGISTRAR'S SIGNATURE Dee Leach	

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FOR STATE
HEALTH DEPT.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FEB 24 1939

BUREAU V. 2

FEB 24 1939

RECEIVED

2454

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural- Cordova				c. LENGTH OF STAY IN 1b 44 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cordova				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha June Asche				4. DATE OF DEATH Month Day Year February 22, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ferdinand Gadow				14. MOTHER'S MAIDEN NAME Annie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mr. George A. Asche, Cordova, RD, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic stenosis (c) Rheumatic carditis				INTERVAL BETWEEN ONSET AND DEATH many years childhood			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 16 , 19 58 , to Feb 21 , 19 58 , and that death occurred on Feb 21 , 19 58 , at 6:22 P.M., from the causes and on the date stated above.				22. ADDRESS (Street, city or town, state) Green Lane, Md.			
ACTUAL SIGNATURE Kurt Lederer				DATE SIGNED			
PHYSICIAN'S NAME (Type) Kurt Lederer M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/58		22c. NAME OF CEMETERY OR CREMATORY St. Paul Church Cem.		22d. LOCATION (City, town, or county) (State) Cordova, RD, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. [Signature]				24a. REC'D BY REGISTRAR DATE FEB 25 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		DATE OF DEATH FEB 25 1958	
DECEASED JAMES J. CORBORE		AGE 45 YRS	
SEX MALE		RACE WHITE	
BIRTH JAN 15 1913		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED	
MARITAL STATUS MARRIED		SPOUSE JANE CORBORE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION	
DATE OF DEATH FEB 25 1958		PLACE OF DEATH HOME	
DECEASED JAMES J. CORBORE		AGE 45 YRS	
SEX MALE		RACE WHITE	
BIRTH JAN 15 1913		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED	
MARITAL STATUS MARRIED		SPOUSE JANE CORBORE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION	

RECEIVED
FEB 25 1958
BUREAU V. 51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 2 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) THE MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE KENNEDY BAILEY				4. DATE OF DEATH Month 2 Day 22 Year 1958			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/58	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years lost birthday) yrs. 20		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Hugh Kennedy BAILEY			
14. MOTHER'S MAIDEN NAME EVELYN WALLACH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mother, Mrs Evelyn Bailey CLAIBORNE, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bi-lateral pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E.C.H. Schmidt				ADDRESS (Street, city or town, state) 2195 West 113rd St			
PHYSICIAN'S NAME (Type) E.C.H. Schmidt				DATE SIGNED 2-22-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/24/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Olivet		22d. LOCATION (City, town, or county) (State) St. Michael, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Norman H. Muehl				ADDRESS St. Michael, Md		24a. REC'D BY REGISTRAR 2-22-58	
24b. REGISTRAR'S SIGNATURE Overman							

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FEB 26 1958

RECEIVED
FEB 26 1958

2427

CERTIFICATE OF DEATH

Reg. Dist. No.

02421

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>7 yrs</u>		d. STREET ADDRESS <u>1 Church Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anastasia Carter Middle Betty</u>		4. DATE OF DEATH Month Day Year <u>Feb. 5 1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>11 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Barber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs W. G. Radlow</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma of colon to liver.</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of colon.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 months.</u> <u>3 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>52</u> , to <u>2-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>58</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>210 E DOVER, EASTON MD.</u> DATE SIGNED <u>3/7/58</u>			
ACTUAL SIGNATURE <u>William L. Winters</u>		M.D. <u>210 E DOVER, EASTON MD.</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>		<u>210 E DOVER, EASTON MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>burial</u>	<u>Feb. 7, 1958</u>	<u>Forest Lawn</u>	<u>Bestuda Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Easton Md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF STATE CLERK	
22. SIGNATURE OF DEPARTMENT CLERK		23. SIGNATURE OF HEALTH COMMISSIONER		24. SIGNATURE OF ATTORNEY GENERAL	
25. SIGNATURE OF JUDGE OF PROBATE		26. SIGNATURE OF SHERIFF		27. SIGNATURE OF CORONER	
28. SIGNATURE OF TOWNSHIP CLERK		29. SIGNATURE OF COUNTY CLERK		30. SIGNATURE OF STATE CLERK	
31. SIGNATURE OF DEPARTMENT CLERK		32. SIGNATURE OF HEALTH COMMISSIONER		33. SIGNATURE OF ATTORNEY GENERAL	
34. SIGNATURE OF JUDGE OF PROBATE		35. SIGNATURE OF SHERIFF		36. SIGNATURE OF CORONER	
37. SIGNATURE OF TOWNSHIP CLERK		38. SIGNATURE OF COUNTY CLERK		39. SIGNATURE OF STATE CLERK	
40. SIGNATURE OF DEPARTMENT CLERK		41. SIGNATURE OF HEALTH COMMISSIONER		42. SIGNATURE OF ATTORNEY GENERAL	
43. SIGNATURE OF JUDGE OF PROBATE		44. SIGNATURE OF SHERIFF		45. SIGNATURE OF CORONER	
46. SIGNATURE OF TOWNSHIP CLERK		47. SIGNATURE OF COUNTY CLERK		48. SIGNATURE OF STATE CLERK	
49. SIGNATURE OF DEPARTMENT CLERK		50. SIGNATURE OF HEALTH COMMISSIONER		51. SIGNATURE OF ATTORNEY GENERAL	
52. SIGNATURE OF JUDGE OF PROBATE		53. SIGNATURE OF SHERIFF		54. SIGNATURE OF CORONER	
55. SIGNATURE OF TOWNSHIP CLERK		56. SIGNATURE OF COUNTY CLERK		57. SIGNATURE OF STATE CLERK	
58. SIGNATURE OF DEPARTMENT CLERK		59. SIGNATURE OF HEALTH COMMISSIONER		60. SIGNATURE OF ATTORNEY GENERAL	
61. SIGNATURE OF JUDGE OF PROBATE		62. SIGNATURE OF SHERIFF		63. SIGNATURE OF CORONER	
64. SIGNATURE OF TOWNSHIP CLERK		65. SIGNATURE OF COUNTY CLERK		66. SIGNATURE OF STATE CLERK	
67. SIGNATURE OF DEPARTMENT CLERK		68. SIGNATURE OF HEALTH COMMISSIONER		69. SIGNATURE OF ATTORNEY GENERAL	
70. SIGNATURE OF JUDGE OF PROBATE		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF CORONER	
73. SIGNATURE OF TOWNSHIP CLERK		74. SIGNATURE OF COUNTY CLERK		75. SIGNATURE OF STATE CLERK	
76. SIGNATURE OF DEPARTMENT CLERK		77. SIGNATURE OF HEALTH COMMISSIONER		78. SIGNATURE OF ATTORNEY GENERAL	
79. SIGNATURE OF JUDGE OF PROBATE		80. SIGNATURE OF SHERIFF		81. SIGNATURE OF CORONER	
82. SIGNATURE OF TOWNSHIP CLERK		83. SIGNATURE OF COUNTY CLERK		84. SIGNATURE OF STATE CLERK	
85. SIGNATURE OF DEPARTMENT CLERK		86. SIGNATURE OF HEALTH COMMISSIONER		87. SIGNATURE OF ATTORNEY GENERAL	
88. SIGNATURE OF JUDGE OF PROBATE		89. SIGNATURE OF SHERIFF		90. SIGNATURE OF CORONER	
91. SIGNATURE OF TOWNSHIP CLERK		92. SIGNATURE OF COUNTY CLERK		93. SIGNATURE OF STATE CLERK	
94. SIGNATURE OF DEPARTMENT CLERK		95. SIGNATURE OF HEALTH COMMISSIONER		96. SIGNATURE OF ATTORNEY GENERAL	
97. SIGNATURE OF JUDGE OF PROBATE		98. SIGNATURE OF SHERIFF		99. SIGNATURE OF CORONER	
100. SIGNATURE OF TOWNSHIP CLERK		101. SIGNATURE OF COUNTY CLERK		102. SIGNATURE OF STATE CLERK	

RECEIVED
FEB 10 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2428

Reg. Dist. No.

02422

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN lb <u>2 days 5 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cordova</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial</u>		d. STREET ADDRESS <u>None</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Bolden</u>	First <u>Bolden</u> Middle <u>Blades</u> Last <u>Blades</u>	4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Estay Poultry Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Blades</u>		14. MOTHER'S MAIDEN NAME <u>Louise Callahan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs Della Blades - Cordova, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Depressed fracture of skull</u> <u>810 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Driving car struck by train</u> (c) <u>Driving car struck by train</u> DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Driving pickup - struck by train at crossing</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving pickup - struck by train at crossing</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> - <u>erm.</u> <u>2-24</u> 19 <u>58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR X at</u>	20f. (City or town) (County) (State) <u>Cordova Tal. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis White</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/11/58</u>		22b. DATE THEREOF <u>2/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Brampton Carroll</u>		ADDRESS <u>Easton Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH USE

BUREAU V. S.

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 7, Film 226 3-10-58 et

2429

CERTIFICATE OF DEATH

02423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARROLL First 1 Middle Brice Last				4. DATE OF DEATH Month 2 Day 18 Year 1958			
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/11/86	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Joseph Brice			
14. MOTHER'S MAIDEN NAME Annie Brooks				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 218-38-109				17. INFORMANT Address Mrs. Maggie Brice, Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pericarditis 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephritis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 2 , 19 56 to Feb. 18 , 19 58 , that I last saw the deceased alive on Feb. 18 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Hayward J. Hill M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/25/58		22c. NAME OF CEMETERY OR CREMATORY New Chapel		22d. LOCATION (City, town, or county) (State) Easton, RT 2, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James B. Doolittle Easton, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE FEB 26 1958							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1923		MOBILE		ALABAMA		U.S.A.		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1948		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
CONDUCTOR		1948		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
HEART DISEASE		2/26/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
NATURAL		2/26/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES EARL RAY		2/26/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES EARL RAY		2/26/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	

BUREAU V. 8

FEB 26 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2455

CERTIFICATE OF DEATH

02424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle W. Last CAULK		4. DATE OF DEATH Month February Day 28 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Rep.		10b. KIND OF BUSINESS OR INDUSTRY Oil	
11. BIRTHPLACE (State or foreign country) St. Michaels, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Caulk		14. MOTHER'S MAIDEN NAME Florence A. Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Bessie B. Caulk, St. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 4.20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic coronary DUE TO (c) heart d.		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-17 , 19 53 to 2-28 , 19 58 , that I last saw the deceased alive on 2-28 , 19 58 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) St Michaels Md DATE SIGNED 2-28-58 ACTUAL SIGNATURE Guy M. Reeser M.D. St Michaels Md PHYSICIAN'S NAME (Type) Guy M Reeser			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stamilton Harrison ADDRESS St Michaels Md		24a. REC'D BY REGISTRAR DATE MAR 5 '58	
24b. REGISTRAR'S SIGNATURE W. B. Smith			

CERTIFICATE OF DEATH

3535

Talbot

Michigan

Michigan

Talbot

St. Michaels

Life

St. Michaels

Chastant Street

CALHOUN

HOWARD

Oct. 2, 1894

White

Male

vi

St. Michaels

Florence A. Turner

William Clark

Home of Mrs. Joseph B. Clark, St. Michaels, Minn.

BUREAU 10

MAR 5 1939

RECEIVED

Funeral Home, 1101 1st St. S. S. S. S.

2430 Item 9 Filing 226 3-3-58 et
CERTIFICATE OF DEATH

02425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>40 Locust st.</u>				d. STREET ADDRESS <u>1 40 Locust st.</u>			
3. NAME OF DECEASED (Type or print) <u>JACOB</u> First Middle Last <u>COPPER</u>				4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Feed mill</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC Copper</u>				14. MOTHER'S MAIDEN NAME <u>Martha Cornish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-16-1496</u>		17. INFORMANT Address <u>Mrs. Harriett Copper, Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial INfARction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>GENERALIZED ARTERIOSclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 minutes</u> <u>2-3 minutes</u> <u>prolonged</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9-22</u> , 19 <u>57</u> , to <u>2-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>58</u> , and that death occurred at <u>6⁰⁰</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Ludwig J. Eglseder</u> M.D.				<u>12 N. HANSON ST, EASTON</u> <u>2-15-58</u>			
PHYSICIAN'S NAME (Type) <u>Ludwig J. Eglseder</u>				<u>MARYLAND</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. E.

FEB 26 1958

RECEIVED

2431 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None given</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Gorman</u> Last <u>Gorman</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1888</u>	
9. AGE (In years lost birth day) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Curtis Cannon</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. Milligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr Henry Gorman</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton 16, Maryland</u>			
DATE SIGNED <u>28 Feb 58</u>							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				M.D. <u>219 S. Washington St. Easton 16, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/1/58</u>		22b. DATE THEREOF <u>3/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reddellows Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Seaford, Dela.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton, Son</u>				ADDRESS <u>Federalburg Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>21. SIGNATURE OF MINISTER</p>		<p>22. SIGNATURE OF RABBI</p>	
<p>23. SIGNATURE OF PRIEST</p>		<p>24. SIGNATURE OF MINISTER</p>	
<p>25. SIGNATURE OF MINISTER</p>		<p>26. SIGNATURE OF MINISTER</p>	
<p>27. SIGNATURE OF MINISTER</p>		<p>28. SIGNATURE OF MINISTER</p>	
<p>29. SIGNATURE OF MINISTER</p>		<p>30. SIGNATURE OF MINISTER</p>	
<p>31. SIGNATURE OF MINISTER</p>		<p>32. SIGNATURE OF MINISTER</p>	
<p>33. SIGNATURE OF MINISTER</p>		<p>34. SIGNATURE OF MINISTER</p>	
<p>35. SIGNATURE OF MINISTER</p>		<p>36. SIGNATURE OF MINISTER</p>	
<p>37. SIGNATURE OF MINISTER</p>		<p>38. SIGNATURE OF MINISTER</p>	
<p>39. SIGNATURE OF MINISTER</p>		<p>40. SIGNATURE OF MINISTER</p>	
<p>41. SIGNATURE OF MINISTER</p>		<p>42. SIGNATURE OF MINISTER</p>	
<p>43. SIGNATURE OF MINISTER</p>		<p>44. SIGNATURE OF MINISTER</p>	
<p>45. SIGNATURE OF MINISTER</p>		<p>46. SIGNATURE OF MINISTER</p>	
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<p>51. SIGNATURE OF MINISTER</p>		<p>52. SIGNATURE OF MINISTER</p>	
<p>53. SIGNATURE OF MINISTER</p>		<p>54. SIGNATURE OF MINISTER</p>	
<p>55. SIGNATURE OF MINISTER</p>		<p>56. SIGNATURE OF MINISTER</p>	
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<p>65. SIGNATURE OF MINISTER</p>		<p>66. SIGNATURE OF MINISTER</p>	
<p>67. SIGNATURE OF MINISTER</p>		<p>68. SIGNATURE OF MINISTER</p>	
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<p>71. SIGNATURE OF MINISTER</p>		<p>72. SIGNATURE OF MINISTER</p>	
<p>73. SIGNATURE OF MINISTER</p>		<p>74. SIGNATURE OF MINISTER</p>	
<p>75. SIGNATURE OF MINISTER</p>		<p>76. SIGNATURE OF MINISTER</p>	
<p>77. SIGNATURE OF MINISTER</p>		<p>78. SIGNATURE OF MINISTER</p>	
<p>79. SIGNATURE OF MINISTER</p>		<p>80. SIGNATURE OF MINISTER</p>	
<p>81. SIGNATURE OF MINISTER</p>		<p>82. SIGNATURE OF MINISTER</p>	
<p>83. SIGNATURE OF MINISTER</p>		<p>84. SIGNATURE OF MINISTER</p>	
<p>85. SIGNATURE OF MINISTER</p>		<p>86. SIGNATURE OF MINISTER</p>	
<p>87. SIGNATURE OF MINISTER</p>		<p>88. SIGNATURE OF MINISTER</p>	
<p>89. SIGNATURE OF MINISTER</p>		<p>90. SIGNATURE OF MINISTER</p>	
<p>91. SIGNATURE OF MINISTER</p>		<p>92. SIGNATURE OF MINISTER</p>	
<p>93. SIGNATURE OF MINISTER</p>		<p>94. SIGNATURE OF MINISTER</p>	
<p>95. SIGNATURE OF MINISTER</p>		<p>96. SIGNATURE OF MINISTER</p>	
<p>97. SIGNATURE OF MINISTER</p>		<p>98. SIGNATURE OF MINISTER</p>	
<p>99. SIGNATURE OF MINISTER</p>		<p>100. SIGNATURE OF MINISTER</p>	

BUREAU V. S.

MAR 3 1958

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2456

CERTIFICATE OF DEATH

02427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Visto Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last GEORGE				4. DATE OF DEATH Month Feb. Day 13, Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1868		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Francis George				14. MOTHER'S MAIDEN NAME Mary Caldwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Wm. S. George, Jr. Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cachexia - severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma prostate & DUE TO (c) Generalized metastases.						INTERVAL BETWEEN ONSET AND DEATH 6 weeks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-12-1952 , to 2-13-1958 , that I last saw the deceased alive on 2-13-1958 , and that death occurred at 8:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Guy M. Beeber Jr.				ADDRESS (Street, city or town, state) St Michaels Md			
PHYSICIAN'S NAME (Type) Guy M Beeber Jr				DATE SIGNED 2-14-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE FEB 19 '58	
				24b. REGISTRAR'S SIGNATURE Rebecca			

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		FEB 19 1958	
NAME OF DECEASED		AGE	
JAMES EARL RAY		35	
SEX		MALE	
RACE		WHITE	
BIRTH DATE		BIRTH PLACE	
JAN 19 1923		MISSOURI	
MANNER OF DEATH		CAUSE OF DEATH	
SUICIDE		HEART DISEASE	
OTHER		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE	
FEB 19 1958		FEB 19 1958	

BUREAU V. 3

FEB 19 1958

RECEIVED

2432 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>25 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Gibson</u> Last <u>Gibson</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 3 1899</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>12</u> Min. <u>00</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hensley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Not known</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Arthur Lee Gibson - son - same</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>604x</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydropneumothorax</u> DUE TO <u>B/Badder stone</u> (c) <u>B/Badder stone</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 23</u> , 19 <u>58</u> , to <u>Feb 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St</u> DATE SIGNED <u>25 Feb 58</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS <u>Easton 16 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Laschell</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR <u>Feb 25 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Lee Gibson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 26 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2433

CERTIFICATE OF DEATH

Reg. Dist. No.

02429

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>16 Elm Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>E Davis</u>		4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 10, 1907</u> 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmund Greenwood</u>		14. MOTHER'S MAIDEN NAME <u>Rose Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1st Mar 4</u>		16. SOCIAL SECURITY NO. <u>217-053761</u>	
17. INFORMANT <u>Mrs Eleanor Greenwood</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Malignant hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>56</u> , to <u>5 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 Feb</u> , 19 <u>58</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u>		ADDRESS (Street, city or town, state) <u>Chesapeake Bay Land</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		DATE SIGNED <u>5 Feb 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 8, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Beach</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

RECEIVED

FEB 7 1958

BUREAU V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02430

2434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Kennard</u> Middle <u>Harrison</u> Last <u>Harrison</u>		4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>yard man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>48-05-735</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel E. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Susan Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-05-735</u>	
17. INFORMANT Address <u>Mrs. Lola Mae Harrison (wife) Sherwood, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiac and</u> DUE TO (c) <u>cerebro-vascular d</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-9-58</u> , 19 <u>-</u> , to <u>2-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>58</u> , and that death occurred at <u>9:40 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>2-12-58</u>	
PHYSICIAN'S NAME (Type) <u>Luy m Reeser</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sherwood Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H Harrison</u> ADDRESS <u>St Michaels Md</u>		24a. REC'D BY REGISTRAR <u>FEB 18 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. 11

FEB 18 1958

RECEIVED

2435

CERTIFICATE OF DEATH

Reg. Dist. No.

03772

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind.</i> b. COUNTY <i>Donahoe</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsburg, Ind.</i> 09X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>		d. STREET ADDRESS <i>None</i>	
3. NAME OF DECEASED (Type or print) First <i>David</i> Middle <i>BENNETT</i> Last <i>Hill</i>		4. DATE OF DEATH Month <i>February</i> Day <i>25</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 21, 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE (In years last birthday) <i>64</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin S. Hill</i>		14. MOTHER'S MAIDEN NAME <i>Emma Dean</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs Edith Lynn (Sister)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary failure</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August</i> , 1957, to <i>Feb</i> , 1958, that I last saw the deceased alive on <i>2/25</i> , 1958, and that death occurred at <i>11:40</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thorston Harrison</i>		ADDRESS (Street, city or town, state) <i>Cathy, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		DATE SIGNED <i>3 Mar 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 1, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Federalsburg, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J J Thompson Son</i>		ADDRESS <i>Federalsburg, Md.</i>	
24a. REC'D BY REGISTRAR <i>WAB</i>		24b. REGISTRAR'S SIGNATURE <i>WAB</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

10 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 02432									
1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital, Easton					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Trappe d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARGARET FAULKNER JONES					4. DATE OF DEATH Feb. 16, 19 58				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1930		9. AGE (In years last birthday) 27 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Thomas Faulkner					14. MOTHER'S MAIDEN NAME Agnes Dadds				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus pneumonia DUE TO 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Dr. Louis S. Welty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. Louis S. Welty					DATE SIGNED 2-18-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Landing Neck Cemetery		22d. LOCATION (City, town, or county) (State) rural Trappe, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son ADDRESS Easton, Md.					24a. REC'D BY REGISTRAR DATE FEB 21 1958		24b. REGISTRAR'S SIGNATURE Ow. Beach		

MISSOURI STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1938

RECEIVED

CHIEF CLERK BOND

CERTIFICATE OF DEATH

Reg. Dist. No.

02433

2457

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miles River Yacht Club				e. STREET ADDRESS Talbot St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Daniel Middle Hughes Last LeCompte				4. DATE OF DEATH Month Feb. Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1905		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicolas LeCompte				14. MOTHER'S MAIDEN NAME Anne Bloodsworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-1658		17. INFORMANT Dorothy LeCompte		Address St. Michaels, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular d. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 hr. -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 2 Year 1958 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-2- , 1958 , to 3-2- , 1958 , that I last saw the deceased alive on 2-2- , 1958 , and that death occurred at 3:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels Md DATE SIGNED 2-3-58							
ACTUAL SIGNATURE Norman D. Marshall M.D.				PHYSICIAN'S NAME (Type) Norman D. Marshall			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Olivet		22d. LOCATION (City, town, or county) (State) St. Michaels Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall				24a. REC'D BY REGISTRAR DATE FEB 5 '58		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2437

CERTIFICATE OF DEATH

Reg. Dist. No.

02434

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> <u>17X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Elizabeth</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/22/1917</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Not known</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Agnes Marshall (Daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO <u>Coronary atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>2/7</u> , 19 <u>58</u> , to <u>2/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u>				ADDRESS (Street, city or town, state) <u>Cheston Maryland</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				DATE SIGNED <u>11 Feb 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stennisville</u>		22d. LOCATION (City, town, or county) (State) <u>Queen Anne Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. OCCUPATION [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. DATE OF BIRTH [Faint text]	
7. PLACE OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]	
15. PLACE OF INTERMENT [Faint text]		16. NAME OF FUNERAL HOME [Faint text]	
17. SIGNATURE OF FUNERAL HOME [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF DECEASED [Faint text]	
23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]	
27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF DECEASED [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF DECEASED [Faint text]	
35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]	
39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF DECEASED [Faint text]	
47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF DECEASED [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]	
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59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]	
63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF DECEASED [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]	
75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF DECEASED [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF DECEASED [Faint text]	
83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]	
87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF DECEASED [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF DECEASED [Faint text]	
95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]	
99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 5

1938 13 23

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02435

2438

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 2 1/4 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE RD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			f. STREET ADDRESS TRAPPE RD.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Steven John NEWCOMB			4. DATE OF DEATH Month FEB Day 11 Year 1958 19		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/45		9. AGE (In years last birthday) 12 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Albany NY	
13. FATHER'S NAME Joyce-Kearney Norman D. Newcomb			14. MOTHER'S MAIDEN NAME Joyce Kearney		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Norman D. Newcomb Address Trappe Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pass. in car which ran under side of trailer of tractor-trailer			
20c. TIME OF INJURY Month, Day, Year 2-11-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hi-way		20f. (City or town) (County) (State) Trappe Talbot Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Louis S. Welty		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/58	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			24b. REGISTRAR'S SIGNATURE 2-11-58		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 14 1958

BUREAU V. E.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2439

02436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE xxx Easton c. LENGTH OF STAY IN 1b RD d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE RD d. STREET ADDRESS TRAPPE RD. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Suzanne Middle NEWCOMB Last NEWCOMB		4. DATE OF DEATH Month FEB Day 11 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/44
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months 11 Days 11	IF UNDER 24 HRS. Hours 11 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Providence Rd Is.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman D. Newcomb		14. MOTHER'S MAIDEN NAME Joyce Kearney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Norman D. Newcomb		Address Trappe Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull-multiple injuries 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) 816X (c), stating the underlying cause lost. (c) 816X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pass. in car which ran under side of trailer of tractor-trailer			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 2-11-58 Hour 8:20 a.m. PM		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hi-way		20f. (City or town) Trappe (County) Talbot (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Louis S. Welty		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-11-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/14/58	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park	22d. LOCATION (City, town, or county) Cambridge (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR FEB 14 '58		24b. REGISTRAR'S SIGNATURE W. J. Seach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 14 1959

RECEIVED

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is oriented horizontally but contains text that is mirrored or bleed-through from the reverse side.

TO BE FILED IN THE OFFICE OF THE
STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

2440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> <u>05X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>MAY</u> Last <u>Nichols</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alex Wright</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Hignett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-38-8718</u>	
17. INFORMANT <u>Marie Nichols, daughter - Federalburg Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Diabetes Mellitus</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>yrs.</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/19</u> , 19 <u>58</u> , to <u>2/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>2/25/58</u>			
ACTUAL SIGNATURE <u>S. Krech Jr</u>		PHYSICIAN'S NAME (Type) <u>SHEPARD KRECH JR</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Free Creek Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton Son</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	

BUREAU V. S.

8361 7 MAR

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2441

CERTIFICATE OF DEATH

Reg. Dist. No.

02438

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE MEMORIAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE 17X-2			
f. STREET ADDRESS None				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle E. Last O'DONNELL				4. DATE OF DEATH Month Feb. Day 27 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 18, 1894	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.I.F.E.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES H. JONES				14. MOTHER'S MAIDEN NAME MARY WYLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-24-0777			
17. INFORMANT Husband				18. ADDRESS SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 Feb , 19 57 , to 27 Feb , 19 57 , that I last saw the deceased alive on 27 Feb , 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thurston Harrison M.D.				ADDRESS (Street, city or town, state) Crofton Maryland DATE SIGNED 3 Mar 58			
PHYSICIAN'S NAME (Type) THURSTON HARRISON							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/3/58		22c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery Stevensville Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Burt ADDRESS Baltimore Md				24a. REC'D BY REGISTRAR Wm. B. Burt		24b. REGISTRAR'S SIGNATURE Wm. B. Burt	
				DATE MAR 5 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	
<p>15. SIGNATURE OF WITNESS [Faint text]</p>		<p>16. SIGNATURE OF DECEASED [Faint text]</p>	
<p>17. SIGNATURE OF WITNESS [Faint text]</p>		<p>18. SIGNATURE OF DECEASED [Faint text]</p>	
<p>19. SIGNATURE OF WITNESS [Faint text]</p>		<p>20. SIGNATURE OF DECEASED [Faint text]</p>	
<p>21. SIGNATURE OF WITNESS [Faint text]</p>		<p>22. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>35. SIGNATURE OF WITNESS [Faint text]</p>		<p>36. SIGNATURE OF DECEASED [Faint text]</p>	
<p>37. SIGNATURE OF WITNESS [Faint text]</p>		<p>38. SIGNATURE OF DECEASED [Faint text]</p>	
<p>39. SIGNATURE OF WITNESS [Faint text]</p>		<p>40. SIGNATURE OF DECEASED [Faint text]</p>	
<p>41. SIGNATURE OF WITNESS [Faint text]</p>		<p>42. SIGNATURE OF DECEASED [Faint text]</p>	
<p>43. SIGNATURE OF WITNESS [Faint text]</p>		<p>44. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>97. SIGNATURE OF WITNESS [Faint text]</p>		<p>98. SIGNATURE OF DECEASED [Faint text]</p>	
<p>99. SIGNATURE OF WITNESS [Faint text]</p>		<p>100. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02439

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Trappe			c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Trappe		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				a. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle LYNN Last PAHLMAN				4. DATE OF DEATH Month Feb. Day 17, Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Retired Machinery Dealer		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME Rudolph Pahlman				14. MOTHER'S MAIDEN NAME Mae Linn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-2391		17. INFORMANT Mrs. Dora Pahlman		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Louis Mitty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Louis S. Welty				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE FEB 21 '58	
				24b. REGISTRAR'S SIGNATURE Over			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02440**

2442

81
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 1 HR. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE d. STREET ADDRESS 112 DARLEY STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LUKE First TR. Middle PARKER Last 4. DATE OF DEATH Month 2 Day 27 Year 1958		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/19/02 9. AGE (In years last birthday) 55 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN 10b. KIND OF BUSINESS OR INDUSTRY same 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES PARKER 14. MOTHER'S MAIDEN NAME AMANDA TOLLEY 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Mrs. Madeline Parker (wife) Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO (b) Explosion on gasoline barge Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Standing on deck of barge at time of explosion 20c. TIME OF INJURY Month, Day, Year 6:10 Hour 2-27 p. m. Year 1958 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tred Avon River 20f. (City or town) (County) (State) Easton - rural Talbot Md		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE L. S. WELTY M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) L S WELTY ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-27-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/30/58 22c. NAME OF CEMETERY OR CREMATORY Easton 22d. LOCATION (City, town, or county) (State) Talbot Md		23. FUNERAL DIRECTOR'S SIGNATURE Edmund ADDRESS Edmund 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Edmund DATE MAR 5 '58					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR FILE
HEALTH DEPT

RECEIVED
BOMD

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAR 5 1958

RECEIVED

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is partially filled out with handwritten text, including "CHRYLES" and "LARRY".

2459

CERTIFICATE OF DEATH

Reg. Dist. No.

02441

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Queen Anne</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Queen Anne</u>			
				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Washington</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 5, 1870</u>	
				9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot County Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>John Henry Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Chancell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs J. Leo Gannon Queen Anne Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Venous disease of the heart</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis & Sclerosis</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 7</u> , 19 <u>58</u> , to <u>Feb 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>58</u> , and that death occurred on <u>Feb 8</u> , 19 <u>58</u> , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. McHenry</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Centerville Md 2/11/58</u>			
PHYSICIAN'S NAME (Type) <u>H. F. McHenry</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Lockhart Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Clark</u>				ADDRESS <u>Clinton Md</u>		24a. REC'D BY REGISTRAR <u>FEB 14 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert L. Clark</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF DEPUTY SHERIFF		19. SIGNATURE OF CONSTABLE		20. SIGNATURE OF JAILER		21. SIGNATURE OF PRISONER		22. SIGNATURE OF GUARD		23. SIGNATURE OF WARDEN		24. SIGNATURE OF CHIEF OF POLICE		25. SIGNATURE OF DEPUTY CHIEF OF POLICE		26. SIGNATURE OF SQUAD LEADER		27. SIGNATURE OF OFFICER		28. SIGNATURE OF SERGEANT		29. SIGNATURE OF DETECTIVE		30. SIGNATURE OF PATROLMAN		31. SIGNATURE OF TRAFFIC OFFICER		32. SIGNATURE OF INVESTIGATOR		33. SIGNATURE OF IDENTIFICATION UNIT		34. SIGNATURE OF LABORATORY		35. SIGNATURE OF MEDICAL EXAMINER		36. SIGNATURE OF PATHOLOGIST		37. SIGNATURE OF ANATOMIST		38. SIGNATURE OF HISTOLOGIST		39. SIGNATURE OF BACTERIOLOGIST		40. SIGNATURE OF VIROLOGIST		41. SIGNATURE OF PARASITOLOGIST		42. SIGNATURE OF ENTOMOLOGIST		43. SIGNATURE OF MALACOLOGIST		44. SIGNATURE OF MYCOLOGIST		45. SIGNATURE OF PLANT PATHOLOGIST		46. SIGNATURE OF ZOOLOGIST		47. SIGNATURE OF BOTANIST		48. SIGNATURE OF GEOLOGIST		49. SIGNATURE OF MINERALOGIST		50. SIGNATURE OF METEOROLOGIST		51. SIGNATURE OF ASTRONOMER		52. SIGNATURE OF PHYSICIST		53. SIGNATURE OF CHEMIST		54. SIGNATURE OF BIOLOGIST		55. SIGNATURE OF PSYCHOLOGIST		56. SIGNATURE OF EDUCATOR		57. SIGNATURE OF SOCIAL SCIENTIST		58. SIGNATURE OF HUMANITIES		59. SIGNATURE OF ARTS		60. SIGNATURE OF LETTERS		61. SIGNATURE OF PHILOSOPHY		62. SIGNATURE OF THEOLOGY		63. SIGNATURE OF LAW		64. SIGNATURE OF MEDICINE		65. SIGNATURE OF DENTISTRY		66. SIGNATURE OF VETERINARY MEDICINE		67. SIGNATURE OF AGRICULTURE		68. SIGNATURE OF FISHERIES		69. SIGNATURE OF FORESTRY		70. SIGNATURE OF MINING		71. SIGNATURE OF ENGINEERING		72. SIGNATURE OF ARCHITECTURE		73. SIGNATURE OF DESIGN		74. SIGNATURE OF CRAFTS		75. SIGNATURE OF MANUFACTURING		76. SIGNATURE OF TRANSPORTATION		77. SIGNATURE OF COMMUNICATIONS		78. SIGNATURE OF ENERGY		79. SIGNATURE OF ENVIRONMENTAL SCIENCE		80. SIGNATURE OF SPACE SCIENCE		81. SIGNATURE OF COMPLEX SCIENCE		82. SIGNATURE OF INTERDISCIPLINARY SCIENCE		83. SIGNATURE OF SCIENCE		84. SIGNATURE OF TECHNOLOGY		85. SIGNATURE OF INNOVATION		86. SIGNATURE OF RESEARCH		87. SIGNATURE OF DEVELOPMENT		88. SIGNATURE OF PROGRESS		89. SIGNATURE OF ADVANCEMENT		90. SIGNATURE OF KNOWLEDGE		91. SIGNATURE OF WISDOM		92. SIGNATURE OF TRUTH		93. SIGNATURE OF JUSTICE		94. SIGNATURE OF FAITH		95. SIGNATURE OF HOPE		96. SIGNATURE OF CHARITY		97. SIGNATURE OF LOVE		98. SIGNATURE OF LIFE		99. SIGNATURE OF DEATH		100. SIGNATURE OF REBIRTH	
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BUREAU V. S.

FEB 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2460

CERTIFICATE OF DEATH

Reg. Dist. No. 02442

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Green Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES HADDAWAY ROSS First Middle Last				4. DATE OF DEATH Feb. 26, Month Day Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1880	
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Adoni Ross				14. MOTHER'S MAIDEN NAME Martha A. Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Martin Petite Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis S. Welty				ADDRESS (Street, city or town, state) Easton Md			
DATE SIGNED 2-27-58				M.D. _____			
PHYSICIAN'S NAME (Type) Louis S. Welty							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE MAR 3 '58	
24b. REGISTRAR'S SIGNATURE W. J. ...							

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]	
4. DATE OF DEATH [Date]		5. TIME OF DEATH [Time]		6. PLACE OF DEATH [Place]	
7. CAUSE OF DEATH [Cause]		8. MANNER OF DEATH [Manner]		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF NEXT OF KIN [Signature]		14. SIGNATURE OF BURIAL SOCIETY [Signature]		15. SIGNATURE OF FUNERAL HOME [Signature]	
16. SIGNATURE OF CHURCH [Signature]		17. SIGNATURE OF CEMETERY [Signature]		18. SIGNATURE OF INTERVIEWER [Signature]	
19. SIGNATURE OF INTERVIEWER [Signature]		20. SIGNATURE OF INTERVIEWER [Signature]		21. SIGNATURE OF INTERVIEWER [Signature]	
22. SIGNATURE OF INTERVIEWER [Signature]		23. SIGNATURE OF INTERVIEWER [Signature]		24. SIGNATURE OF INTERVIEWER [Signature]	
25. SIGNATURE OF INTERVIEWER [Signature]		26. SIGNATURE OF INTERVIEWER [Signature]		27. SIGNATURE OF INTERVIEWER [Signature]	
28. SIGNATURE OF INTERVIEWER [Signature]		29. SIGNATURE OF INTERVIEWER [Signature]		30. SIGNATURE OF INTERVIEWER [Signature]	
31. SIGNATURE OF INTERVIEWER [Signature]		32. SIGNATURE OF INTERVIEWER [Signature]		33. SIGNATURE OF INTERVIEWER [Signature]	
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49. SIGNATURE OF INTERVIEWER [Signature]		50. SIGNATURE OF INTERVIEWER [Signature]		51. SIGNATURE OF INTERVIEWER [Signature]	
52. SIGNATURE OF INTERVIEWER [Signature]		53. SIGNATURE OF INTERVIEWER [Signature]		54. SIGNATURE OF INTERVIEWER [Signature]	
55. SIGNATURE OF INTERVIEWER [Signature]		56. SIGNATURE OF INTERVIEWER [Signature]		57. SIGNATURE OF INTERVIEWER [Signature]	
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67. SIGNATURE OF INTERVIEWER [Signature]		68. SIGNATURE OF INTERVIEWER [Signature]		69. SIGNATURE OF INTERVIEWER [Signature]	
70. SIGNATURE OF INTERVIEWER [Signature]		71. SIGNATURE OF INTERVIEWER [Signature]		72. SIGNATURE OF INTERVIEWER [Signature]	
73. SIGNATURE OF INTERVIEWER [Signature]		74. SIGNATURE OF INTERVIEWER [Signature]		75. SIGNATURE OF INTERVIEWER [Signature]	
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79. SIGNATURE OF INTERVIEWER [Signature]		80. SIGNATURE OF INTERVIEWER [Signature]		81. SIGNATURE OF INTERVIEWER [Signature]	
82. SIGNATURE OF INTERVIEWER [Signature]		83. SIGNATURE OF INTERVIEWER [Signature]		84. SIGNATURE OF INTERVIEWER [Signature]	
85. SIGNATURE OF INTERVIEWER [Signature]		86. SIGNATURE OF INTERVIEWER [Signature]		87. SIGNATURE OF INTERVIEWER [Signature]	
88. SIGNATURE OF INTERVIEWER [Signature]		89. SIGNATURE OF INTERVIEWER [Signature]		90. SIGNATURE OF INTERVIEWER [Signature]	
91. SIGNATURE OF INTERVIEWER [Signature]		92. SIGNATURE OF INTERVIEWER [Signature]		93. SIGNATURE OF INTERVIEWER [Signature]	
94. SIGNATURE OF INTERVIEWER [Signature]		95. SIGNATURE OF INTERVIEWER [Signature]		96. SIGNATURE OF INTERVIEWER [Signature]	
97. SIGNATURE OF INTERVIEWER [Signature]		98. SIGNATURE OF INTERVIEWER [Signature]		99. SIGNATURE OF INTERVIEWER [Signature]	
100. SIGNATURE OF INTERVIEWER [Signature]		101. SIGNATURE OF INTERVIEWER [Signature]		102. SIGNATURE OF INTERVIEWER [Signature]	

RECEIVED
MAR 3 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02443

2461

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> 14X-2 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE WILLIAM RUSSELL</u>		4. DATE OF DEATH Month Day Year <u>Feb. 27, 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1902</u>
9. AGE (in years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jesse William Russell</u>		14. MOTHER'S MAIDEN NAME <u>Mary S. Miles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>524-22-2973</u>	
17. INFORMANT <u>Mr. J. R. Grant</u>		Address <u>North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Explosion - tanker pump room</u> <u>857X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Inhalation flame</u> (c) <u>857X</u> DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>857X</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>explosion in pump room -</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour 2-27 1958</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>River</u>		20f. (City or town) (County) (State) <u>N. Easton Tal. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lavin M. Harty</u>		DATE SIGNED <u>3-1-58</u>	
EXAMINER'S NAME (Type) <u>Dr. L. S. Welty</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 2, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Grant</u> <u>Joseph P. Grant</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Paul ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW STATE
HEALTH DEPT

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

MAR 4 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02444

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 212 N. Aurora St.		d. STREET ADDRESS 212 N. Aurora St.	
3. NAME OF DECEASED (Type or print) ANNIE CATHERINE SALMON		4. DATE OF DEATH Feb. 19, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1883
9. AGE (In years and birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 19 58	
10a. USUAL OCCUPATION (Give kind of work done during last year, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. Davis		14. MOTHER'S MAIDEN NAME Georgiana Saulsbury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-0084A	
17. INFORMANT Mr. Percy A. Davis		Address Easton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Louis S. Welty		DATE SIGNED 2-20-58	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Feb. 22, 1958	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton	
24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
DEPARTMENT OF HEALTH

NAME OF DECEASED
AGE

SEX

DATE OF DEATH

PLACE OF DEATH
CITY

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

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DATE OF DEATH

TIME OF DEATH

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MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

BUREAU V. S.

FEB 04 1903

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2444

CERTIFICATE OF DEATH

Reg. Dist. No.

112445

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Dorchester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlock</u> 09X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>R.F.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Bay Sampson</u>		4. DATE OF DEATH Month Day Year <u>February 21 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 21, 1958</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leon Francis Sampson</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Victoria Stanley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Leon Sampson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/21</u> , 19 <u>58</u> , to <u>2/21</u> , 19 <u>58</u> that I last saw the deceased alive on <u>2/21</u> , 19 <u>58</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton MD</u> DATE SIGNED <u>2/25/58</u>			
ACTUAL SIGNATURE <u>John E. Baybutt</u> M.D.		PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Easton MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____		24a. REC'D BY REGISTRAR _____ DATE _____	
24b. REGISTRAR'S SIGNATURE _____			

2080225XV6

BUREAU V. S.

FEB 26 1958

RECEIVED
FEB 26 1958

2445

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>14 BERRY ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>L.</u> Last <u>Schells</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Sadie L. Beachum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Mr Oscar Schells</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the ovary</u> DUE TO (b) <u>Abdominal cancer metastasis</u> DUE TO (c) <u>175.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>58</u> , to <u>2/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/1/58</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur B. Cecil</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>		DATE SIGNED <u>2/3/58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR B. CECEL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Harrison</u> ADDRESS <u>St Michaels, Md</u>				24. REC'D BY REGISTRAR <u>FFB</u> DATE <u>Feb 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. MEDICAL HISTORY		12. PRESENT ILLNESS		13. TREATMENT		14. POST-MORTEM		15. SIGNATURE OF PHYSICIAN	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CLERK		19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	

BUREAU V. S.

FEB 4 1958

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova Easton				c. LENGTH OF STAY IN 1b 71			
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Stevens Last Stevens				4. DATE OF DEATH Month 2 Day 24 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1887	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME William Stevens			
14. MOTHER'S MAIDEN NAME Julia Perry				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Mrs. Beulah Stevens, Cordova R.D. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia Left 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Embolism DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 2/17/58 2/13/58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic coronary disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 2/13 , 19 58 , to 2/24 , 19 58 , that I lost saw the deceased alive on 2/23 , 19 58 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) Easton Md				21. DATE SIGNED 2/25/58			
ACTUAL SIGNATURE P E Cox MD				PHYSICIAN'S NAME (Type) P E Cox MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Hillsboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Conell				ADDRESS EASTON, MD.		24a. REC'D BY REGISTRAR DATE FEB 27 '58	
24b. REGISTRAR'S SIGNATURE W. H. Conell							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
Charles		Male		30		1910	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
Baltimore		Maryland		United States		United States	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
Student		High School		Married		Roman Catholic	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Feb. 27, 1958		Baltimore		Heart Disease		Natural	
TIME OF DEATH		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
10:00 AM		St. Mary's Cemetery		John's Funeral Home		Rev. J. J. Smith	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		NAME OF REGISTRAR		NAME OF CLERK	
Feb. 27, 1958		Baltimore		John's Funeral Home		Rev. J. J. Smith	

RECEIVED
FEB 27 1958
BUREAU V. S.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2447

CERTIFICATE OF DEATH

Reg. Dist. No.

02448

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>LOUISE</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>16</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/15/82</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALEC THOMPSON</u>				14. MOTHER'S MARDEN NAME <u>JULIE LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Ms Eleanor Jones daughter</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>2/5</u> , 19 <u>58</u> , to <u>2/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>58</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. <u>Carver, Maryland 1965</u> PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md. L.A. County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR _____		24b. REGISTRAR'S SIGNATURE _____	
				DATE <u>FEB 21 '58</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form No. 10

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. DATE OF DEATH [Faint text]</p>		<p>10. PLACE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

FEB 21 1958

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2448

CERTIFICATE OF DEATH

Reg. Dist. No.

02449

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> 178-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>B.</u> Last <u>Turner</u>				4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 20 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Turner</u>			
14. MOTHER'S MAIDEN NAME <u>Virginia Chambers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT Address <u>Mrs. Frances Turner (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1958</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>58</u> , to <u>Feb 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>58</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Coy</u> M.D. <u>Easton Md</u>				DATE SIGNED <u>2/20/58</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Coy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) (State) <u>Queen Anne's Ca Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L Lane</u> ADDRESS <u>Church Hill Md</u>				24a. REC'D BY REGISTRAR <u>Feb 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Deane</u>	

CERTIFICATE OF DEATH

5088

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH May 19, 1928		6. PLACE OF BIRTH Jackson, Mississippi	
7. CITY OR TOWN (State or foreign) Memphis, Tennessee		8. COUNTY Shelby		9. STATE Tennessee		10. COUNTRY United States of America		11. MARITAL STATUS Single		12. OCCUPATION None	
13. DATE OF DEATH April 4, 1968		14. TIME OF DEATH 10:00 AM		15. PLACE OF DEATH Memphis, Tennessee		16. CAUSE OF DEATH Gunshot wound		17. MANNER OF DEATH Suicide		18. MEDICAL HISTORY None	
19. SIGNATURE OF DECEASED None		20. SIGNATURE OF WITNESS None		21. SIGNATURE OF PHYSICIAN None		22. SIGNATURE OF CORONER None		23. SIGNATURE OF JURY None		24. SIGNATURE OF DEATH CERTIFICATE None	

BUREAU V. S.

FEB 21 1968

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2449

CERTIFICATE OF DEATH

Reg. Dist. No.

02450

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CORDOVA - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Genevieve</u> Last <u>WADE</u>			4. DATE OF DEATH Month <u>2</u> - Day <u>10</u> - Year <u>1958</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/67</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MASSACHUSETTS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM E. WOOD</u>				14. MOTHER'S MAIDEN NAME <u>SYLVIA RAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Russell Smith, Jr. Easton Md</u>		Address <u>Grandchester</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery, bilateral</u> <u>170 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>219 S Washington St</u> , 19 <u>58</u> , to <u>16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. CH Schmidt</u>			M.D. <u>219 S Washington St</u> DATE SIGNED <u>11 Feb 58</u>				
PHYSICIAN'S NAME (Type) <u>E. CH Schmidt</u>			ADDRESS <u>Easton 16, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas D. Marshall - St. Michael</u>				ADDRESS <u>St. Michael</u>		24. REC'D BY REGISTRAR DATE <u>FEB 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>DeWitt</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF SHERIFF'S DEPUTY		21. SIGNATURE OF SHERIFF'S CLERK	
22. SIGNATURE OF SHERIFF'S DEPUTY		23. SIGNATURE OF SHERIFF'S CLERK		24. SIGNATURE OF SHERIFF'S CLERK	
25. SIGNATURE OF SHERIFF'S CLERK		26. SIGNATURE OF SHERIFF'S CLERK		27. SIGNATURE OF SHERIFF'S CLERK	
28. SIGNATURE OF SHERIFF'S CLERK		29. SIGNATURE OF SHERIFF'S CLERK		30. SIGNATURE OF SHERIFF'S CLERK	
31. SIGNATURE OF SHERIFF'S CLERK		32. SIGNATURE OF SHERIFF'S CLERK		33. SIGNATURE OF SHERIFF'S CLERK	
34. SIGNATURE OF SHERIFF'S CLERK		35. SIGNATURE OF SHERIFF'S CLERK		36. SIGNATURE OF SHERIFF'S CLERK	
37. SIGNATURE OF SHERIFF'S CLERK		38. SIGNATURE OF SHERIFF'S CLERK		39. SIGNATURE OF SHERIFF'S CLERK	
40. SIGNATURE OF SHERIFF'S CLERK		41. SIGNATURE OF SHERIFF'S CLERK		42. SIGNATURE OF SHERIFF'S CLERK	
43. SIGNATURE OF SHERIFF'S CLERK		44. SIGNATURE OF SHERIFF'S CLERK		45. SIGNATURE OF SHERIFF'S CLERK	
46. SIGNATURE OF SHERIFF'S CLERK		47. SIGNATURE OF SHERIFF'S CLERK		48. SIGNATURE OF SHERIFF'S CLERK	
49. SIGNATURE OF SHERIFF'S CLERK		50. SIGNATURE OF SHERIFF'S CLERK		51. SIGNATURE OF SHERIFF'S CLERK	
52. SIGNATURE OF SHERIFF'S CLERK		53. SIGNATURE OF SHERIFF'S CLERK		54. SIGNATURE OF SHERIFF'S CLERK	
55. SIGNATURE OF SHERIFF'S CLERK		56. SIGNATURE OF SHERIFF'S CLERK		57. SIGNATURE OF SHERIFF'S CLERK	
58. SIGNATURE OF SHERIFF'S CLERK		59. SIGNATURE OF SHERIFF'S CLERK		60. SIGNATURE OF SHERIFF'S CLERK	
61. SIGNATURE OF SHERIFF'S CLERK		62. SIGNATURE OF SHERIFF'S CLERK		63. SIGNATURE OF SHERIFF'S CLERK	
64. SIGNATURE OF SHERIFF'S CLERK		65. SIGNATURE OF SHERIFF'S CLERK		66. SIGNATURE OF SHERIFF'S CLERK	
67. SIGNATURE OF SHERIFF'S CLERK		68. SIGNATURE OF SHERIFF'S CLERK		69. SIGNATURE OF SHERIFF'S CLERK	
70. SIGNATURE OF SHERIFF'S CLERK		71. SIGNATURE OF SHERIFF'S CLERK		72. SIGNATURE OF SHERIFF'S CLERK	
73. SIGNATURE OF SHERIFF'S CLERK		74. SIGNATURE OF SHERIFF'S CLERK		75. SIGNATURE OF SHERIFF'S CLERK	
76. SIGNATURE OF SHERIFF'S CLERK		77. SIGNATURE OF SHERIFF'S CLERK		78. SIGNATURE OF SHERIFF'S CLERK	
79. SIGNATURE OF SHERIFF'S CLERK		80. SIGNATURE OF SHERIFF'S CLERK		81. SIGNATURE OF SHERIFF'S CLERK	
82. SIGNATURE OF SHERIFF'S CLERK		83. SIGNATURE OF SHERIFF'S CLERK		84. SIGNATURE OF SHERIFF'S CLERK	
85. SIGNATURE OF SHERIFF'S CLERK		86. SIGNATURE OF SHERIFF'S CLERK		87. SIGNATURE OF SHERIFF'S CLERK	
88. SIGNATURE OF SHERIFF'S CLERK		89. SIGNATURE OF SHERIFF'S CLERK		90. SIGNATURE OF SHERIFF'S CLERK	
91. SIGNATURE OF SHERIFF'S CLERK		92. SIGNATURE OF SHERIFF'S CLERK		93. SIGNATURE OF SHERIFF'S CLERK	
94. SIGNATURE OF SHERIFF'S CLERK		95. SIGNATURE OF SHERIFF'S CLERK		96. SIGNATURE OF SHERIFF'S CLERK	
97. SIGNATURE OF SHERIFF'S CLERK		98. SIGNATURE OF SHERIFF'S CLERK		99. SIGNATURE OF SHERIFF'S CLERK	
100. SIGNATURE OF SHERIFF'S CLERK		101. SIGNATURE OF SHERIFF'S CLERK		102. SIGNATURE OF SHERIFF'S CLERK	

BUREAU V. S.

FEB 14 1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2450
CERTIFICATE OF DEATH

02451

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SILAS</u> Middle <u>REED</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21, 1874</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM T. WALKER</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE KEMP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>not known</u>	
17. INFORMANT <u>Mrs John A Seiler (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple abscesses of lung</u> <u>521X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fungus, type undetermined</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>2195 West Hilltop St. 13176</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE SIGNED <u>Feb 11 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion C. Newnam</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John V. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>Baltimore, Md.</i>		5. DATE OF BIRTH <i>Jan 15, 1900</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Engineer</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. DATE OF DEATH <i>Feb 18, 1938</i>		11. TIME OF DEATH <i>10:30 AM</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
13. SIGNATURE OF REGISTRAR <i>John V. Smith</i>		14. SIGNATURE OF WITNESSES <i>John V. Smith</i>		15. SIGNATURE OF DECEASED <i>John V. Smith</i>	
16. SIGNATURE OF DECEASED <i>John V. Smith</i>		17. SIGNATURE OF DECEASED <i>John V. Smith</i>		18. SIGNATURE OF DECEASED <i>John V. Smith</i>	
19. SIGNATURE OF DECEASED <i>John V. Smith</i>		20. SIGNATURE OF DECEASED <i>John V. Smith</i>		21. SIGNATURE OF DECEASED <i>John V. Smith</i>	
22. SIGNATURE OF DECEASED <i>John V. Smith</i>		23. SIGNATURE OF DECEASED <i>John V. Smith</i>		24. SIGNATURE OF DECEASED <i>John V. Smith</i>	
25. SIGNATURE OF DECEASED <i>John V. Smith</i>		26. SIGNATURE OF DECEASED <i>John V. Smith</i>		27. SIGNATURE OF DECEASED <i>John V. Smith</i>	
28. SIGNATURE OF DECEASED <i>John V. Smith</i>		29. SIGNATURE OF DECEASED <i>John V. Smith</i>		30. SIGNATURE OF DECEASED <i>John V. Smith</i>	
31. SIGNATURE OF DECEASED <i>John V. Smith</i>		32. SIGNATURE OF DECEASED <i>John V. Smith</i>		33. SIGNATURE OF DECEASED <i>John V. Smith</i>	
34. SIGNATURE OF DECEASED <i>John V. Smith</i>		35. SIGNATURE OF DECEASED <i>John V. Smith</i>		36. SIGNATURE OF DECEASED <i>John V. Smith</i>	
37. SIGNATURE OF DECEASED <i>John V. Smith</i>		38. SIGNATURE OF DECEASED <i>John V. Smith</i>		39. SIGNATURE OF DECEASED <i>John V. Smith</i>	
40. SIGNATURE OF DECEASED <i>John V. Smith</i>		41. SIGNATURE OF DECEASED <i>John V. Smith</i>		42. SIGNATURE OF DECEASED <i>John V. Smith</i>	
43. SIGNATURE OF DECEASED <i>John V. Smith</i>		44. SIGNATURE OF DECEASED <i>John V. Smith</i>		45. SIGNATURE OF DECEASED <i>John V. Smith</i>	
46. SIGNATURE OF DECEASED <i>John V. Smith</i>		47. SIGNATURE OF DECEASED <i>John V. Smith</i>		48. SIGNATURE OF DECEASED <i>John V. Smith</i>	
49. SIGNATURE OF DECEASED <i>John V. Smith</i>		50. SIGNATURE OF DECEASED <i>John V. Smith</i>		51. SIGNATURE OF DECEASED <i>John V. Smith</i>	
52. SIGNATURE OF DECEASED <i>John V. Smith</i>		53. SIGNATURE OF DECEASED <i>John V. Smith</i>		54. SIGNATURE OF DECEASED <i>John V. Smith</i>	
55. SIGNATURE OF DECEASED <i>John V. Smith</i>		56. SIGNATURE OF DECEASED <i>John V. Smith</i>		57. SIGNATURE OF DECEASED <i>John V. Smith</i>	
58. SIGNATURE OF DECEASED <i>John V. Smith</i>		59. SIGNATURE OF DECEASED <i>John V. Smith</i>		60. SIGNATURE OF DECEASED <i>John V. Smith</i>	
61. SIGNATURE OF DECEASED <i>John V. Smith</i>		62. SIGNATURE OF DECEASED <i>John V. Smith</i>		63. SIGNATURE OF DECEASED <i>John V. Smith</i>	
64. SIGNATURE OF DECEASED <i>John V. Smith</i>		65. SIGNATURE OF DECEASED <i>John V. Smith</i>		66. SIGNATURE OF DECEASED <i>John V. Smith</i>	
67. SIGNATURE OF DECEASED <i>John V. Smith</i>		68. SIGNATURE OF DECEASED <i>John V. Smith</i>		69. SIGNATURE OF DECEASED <i>John V. Smith</i>	
70. SIGNATURE OF DECEASED <i>John V. Smith</i>		71. SIGNATURE OF DECEASED <i>John V. Smith</i>		72. SIGNATURE OF DECEASED <i>John V. Smith</i>	
73. SIGNATURE OF DECEASED <i>John V. Smith</i>		74. SIGNATURE OF DECEASED <i>John V. Smith</i>		75. SIGNATURE OF DECEASED <i>John V. Smith</i>	
76. SIGNATURE OF DECEASED <i>John V. Smith</i>		77. SIGNATURE OF DECEASED <i>John V. Smith</i>		78. SIGNATURE OF DECEASED <i>John V. Smith</i>	
79. SIGNATURE OF DECEASED <i>John V. Smith</i>		80. SIGNATURE OF DECEASED <i>John V. Smith</i>		81. SIGNATURE OF DECEASED <i>John V. Smith</i>	
82. SIGNATURE OF DECEASED <i>John V. Smith</i>		83. SIGNATURE OF DECEASED <i>John V. Smith</i>		84. SIGNATURE OF DECEASED <i>John V. Smith</i>	
85. SIGNATURE OF DECEASED <i>John V. Smith</i>		86. SIGNATURE OF DECEASED <i>John V. Smith</i>		87. SIGNATURE OF DECEASED <i>John V. Smith</i>	
88. SIGNATURE OF DECEASED <i>John V. Smith</i>		89. SIGNATURE OF DECEASED <i>John V. Smith</i>		90. SIGNATURE OF DECEASED <i>John V. Smith</i>	
91. SIGNATURE OF DECEASED <i>John V. Smith</i>		92. SIGNATURE OF DECEASED <i>John V. Smith</i>		93. SIGNATURE OF DECEASED <i>John V. Smith</i>	
94. SIGNATURE OF DECEASED <i>John V. Smith</i>		95. SIGNATURE OF DECEASED <i>John V. Smith</i>		96. SIGNATURE OF DECEASED <i>John V. Smith</i>	
97. SIGNATURE OF DECEASED <i>John V. Smith</i>		98. SIGNATURE OF DECEASED <i>John V. Smith</i>		99. SIGNATURE OF DECEASED <i>John V. Smith</i>	
100. SIGNATURE OF DECEASED <i>John V. Smith</i>		101. SIGNATURE OF DECEASED <i>John V. Smith</i>		102. SIGNATURE OF DECEASED <i>John V. Smith</i>	

RECEIVED
FEB 18 1938
BUREAU V. S.

2451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>1 day 2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Warner</u> Last <u>Warner</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>debarer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Warner</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>230-32-9153</u>				17. INFORMANT <u>Rosetta Warner</u> Address <u>Br Michael Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>20 Feb</u> , 19 <u>58</u> , to <u>21 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 Feb</u> , 19 <u>58</u> , and that death occurred at <u>10:40 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D.				DATE SIGNED <u>2-23-58</u>			
PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>				ADDRESS (Street, city or town, state) <u>Box 487 St. Michaels Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Hamilton</u> ADDRESS <u>St. Michaels Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 25 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2021

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Immediate cause of death: _____</p>	
<p>9. Contributing causes: _____</p>		<p>10. Manner of death: _____</p>	
<p>11. Signature of physician: _____</p>		<p>12. Signature of registrar: _____</p>	
<p>13. Date of registration: _____</p>		<p>14. Place of registration: _____</p>	
<p>15. Name of informant: _____</p>		<p>16. Address of informant: _____</p>	
<p>17. Signature of informant: _____</p>		<p>18. Date of completion: _____</p>	

BUREAU V. 8

FEB 25 1958

RECEIVED

02453

2452

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>MRS. Mary</u> First <u>Whiteley</u> Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Satterfield</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Millard Whiteley son -</u> Address <u>Preston, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intentional Obstruction</u> <u>570.5</u> DUE TO (b) <u>Adhesive band</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>7:48</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Westinghouse St. 3 Feb 58</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		M.D. <u>219 S. Westinghouse St. 3 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		<u>Easton Md, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/4/58</u>		22b. NAME OF CEMETERY OR CREMATORY <u>M.E. Church yard</u>	
22c. LOCATION (City, town, or county) <u>Preston Md</u>		(State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry M. Williams</u> ADDRESS <u>Preston, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W.D. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 124

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. 5

FEB 4 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02454

2462

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall 14X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARCELLUS Middle KARCHER Last WITT		4. DATE OF DEATH Month Feb. 27, Day 19 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1913
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.	IF UNDER 24 HRS. Months 44 Days 44 Hours 44 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil barge Captain		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William C. Witt		14. MOTHER'S MAIDEN NAME Eolin Witt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dorothy Witt		Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Explosion - tanker pump room 857X DUE TO Inhalation flame Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 857X DUE TO Inhalation flame (c) 857X DUE TO Inhalation flame			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Explosion in pump room on barge	
20c. TIME OF INJURY Month, Day, Year 6:10 p.m. 7-27 58	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	20f. (City or town) (County) (State) Rock Hall Tal Kent
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Louis S. Welty		DATE SIGNED 3-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 2, 1958	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane		24. REC'D BY REGISTRAR DATE MAR 6 '58	
24b. REGISTRAR'S SIGNATURE Edgar Lane			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

MAR 6 1958

RECEIVED